

PROOF OF CLAIM ADDENDUM (POC Form 3)

EMPLOYEE NAME _____

Check only 1 box on this form. You must complete this form for each benefit requested.

☐ Temporary Disability ☐ Permanent Disability ☐ Current Medical Care ☐ Future Medical Care☐ Other _____

AMOUNT CLAIMED

\$

Describe the basis for the amount claimed for this benefit. You may attach supporting documents as appropriate. If you attach a supporting document, YOU MUST PLACE AN EXHIBIT NUMBER ON THE DOCUMENT AND IDENTIFY THE DOCUMENT WITH THE EXHIBIT NUMBER ON THIS FORM. (For example: "See attached EXHIBIT 2, Doctor's Report dated 02/02/02".)

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.